Coroners Act 1996
[Section 26(1)]

Coroner's Court of Western Australia

RECORD OF INVESTIGATION INTO DEATH

Ref: [2020] WACOR 12

I, Sarah Helen Linton, Coroner, having investigated the death of ***Michael Warren DYBALL*** *with an inquest held at the* ***Perth Coroner's Court, Court 85, CLC Building, 501 Hay Street, Perth*** *on* ***22 May 2020*** *find that the identity of the deceased person was* ***Michael Warren DYBALL*** *and that death occurred on* ***1 May 2016*** *at* ***Fiona Stanley Hospital*** *as a result of* ***bronchopneumonia complicated by multiorgan failure and hypoxic ischaemic encephalopathy in a man with treated squamous cell carcinoma of the tongue*** *in the following circumstances:*

Counsel Appearing:

Sgt L Houisaux assisting the Coroner.
Ms R Hartley (State Solicitor's Office) appearing on behalf of the Department of Justice (Corrective Services).

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INTRODUCTION

1. Michael Dyball was charged and convicted of the attempted murder of his partner on 23 January 2010. He was sentenced in February 2012 to a term of eight years' imprisonment with eligibility for parole, with the sentence backdated to commence on 23 January 2010.

2. Prior to his imprisonment, Mr Dyball had been diagnosed with kidney disease and saw a kidney specialist. While serving his sentence he suffered chronic renal failure and was also diagnosed with an oropharyngeal tumour at the base of his tongue. He received medical treatment for both, but his health continued to deteriorate. The treatments for the tumour left Mr Dyball unable to swallow or talk and he had to have a PEG tube inserted to be fed. As his health deteriorated, he was cared for in the Casuarina Prison Infirmary with input from various specialist hospital teams.

3. Mr Dyball applied for parole in January 2016 but his application was denied by the Prisoner review Board.[1] He continued to receive medical care in the Casuarina Prison Infirmary. At 7.30 am on 28 April 2016, Mr Dyball was found unresponsive in his bed in the Infirmary. Cardiopulmonary resuscitation was commenced by health centre staff and an ambulance attended and took Mr Dyball to Fiona Stanley Hospital, where he was admitted to the Intensive Care Unit. After consultation with Mr Dyball's family, a decision was made to palliate him, and he was kept comfortable until he died in hospital on 1 May 2016.

4. By virtue of being a sentenced prisoner at the time of his death, Mr Dyball was a 'person held in care' for the purposes of the *Coroners Act 1996* (WA). In such circumstances, a coronial inquest is mandatory.[2] I held an inquest at the Perth Coroner's Court on 22 May 2020. At the inquest, extensive written material was tendered in relation to Mr Dyball's medical care while in custody.[3] In addition, two witnesses from the Department were called to give limited oral evidence.

5. Mr Dyball's family had raised some concerns about the standard of medical treatment provided and its timing. In particular, they were concerned that his throat cancer was not dealt with promptly after it was diagnosed. To address their concerns, an expert opinion was obtained from Dr Jee Kong, a General Physician and Gastroenterologist, prior to the inquest. After reviewing the medical records, Dr Kong expressed the opinion that the medical care provided to Mr Dyball for all his chronic medical conditions was reasonable and appropriate.[4]

6. I have given consideration to all of the evidence before me as to Mr Dyball's supervision, treatment and care while he was a prisoner, including Dr Kong's expert opinion. I have concluded that his care was of a high standard and equivalent to what Mr Dyball would have been able to receive if out in the community.

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[1] Exhibit 3, Tab 56 – DIC report.
[2] Section 22(1)(a) *Coroners Act*.
[3] Exhibits 1 to 3.
[4] Exhibit 1, Tab 48.

BACKGROUND

7. Mr Dyball was born in Sydney and had a somewhat chaotic upbringing. He spent time in a children's home and with his grandmother, who was an alcoholic, after his mother abandoned him and his father served time in prison. He left home at around 15 years of age and lived a transient lifestyle, travelling around Australia until he settled in Western Australia in 1982. He formed a relationship when he was 19 years old and they married and had two daughters. After marrying, he settled down and started working for a removal company. When his marriage ended, Mr Dyball started a new relationship in the early 2000's with the victim of the offence that led to his prison sentence.[5]

8. Mr Dyball was diagnosed with kidney disease in 2006. At the time of diagnosis his results from testing were consistent with Stage 4 (Severe) Chronic Kidney Disease. He was monitored through the Renal Clinic at Royal Perth Hospital and his primary renal physician was Dr Kevin Warr.[6]

9. Mr Dyball and his new partner had been together for a number of years before they separated in December 2009 due to problems in their relationship. Mr Dyball had become convinced his partner had formed a relationship with a colleague. On 23 January 2010, Mr Dyball was driving in his car with his partner when he confronted her and stabbed her repeatedly while telling her he was going to kill her. After she escaped from the car, he chased her and stabbed her repeatedly again before bystanders intervened. Mr Dyball then stabbed himself a number of times before he was stopped by one of the bystanders.[7] Mr Dyball's partner was lucky to survive her injuries and was left with permanent injuries and disabilities.[8]

10. Mr Dyball pleaded guilty to the offence on the first day of the listed trial. He was sentenced on 17 February 2012 to 8 years' imprisonment and the sentence was backdated to commence on 23 January 2010, when he first went into custody. The earliest date that he was eligible for release on parole was 22 January 2016.[9]

11. Psychiatric reports before the learned sentencing Judge indicated Mr Dyball had a depressive illness at the time of the offending and he was suffering from an anxiety disorder and major depression at the time he was sentenced.[10]

EARLY CARE IN PRISON

12. When Mr Dyball was first admitted to prison he expressed some concerns about how he would cope and could not guarantee his own safety, so he was placed on the At Risk Management System (ARMS). He was housed in a safe cell in the Crisis Care Unit under medical observation and seen by a

[5] Exhibit 1, Tab 7 and Tab 9.
[6] Exhibit 1, Tab 49A.
[7] Exhibit 1, Tab 9.
[8] Exhibit 1, Tab 9.
[9] Exhibit 3, Tab 56-13.
[10] Exhibit 1, Tab 9.

psychiatrist, who prescribed antidepressants, and the Prison Counselling Service. He was eventually released into mainstream placement on 9 February 2010, but continued to be monitored on ARMS.[11]

13. On 21 February 2010 Mr Dyball self-harmed by lacerating his wrists. He required surgical repair to a damaged nerve at Royal Perth Hospital. He was placed in the Crisis Care Unit again on his return from hospital and remained there until 2 March 2010.[12]

14. Mr Dyball's mental health appeared to settle down after this time and he began to participate in prison life. He became actively involved in education and university studies but sadly his participation in education and ability to participate in programs eventually ceased due to his deteriorating health.

15. Mr Dyball's history of kidney disease and high blood pressure were noted on his admission to prison. His kidney disease continued to be treated by Dr Warr while in prison. Aranesp medication and iron infusions were used to treat his anaemia, which is a feature of chronic kidney disease.[13] Dialysis treatment was discussed with Mr Dyball in February 2010, not long after he was imprisoned, and it was documented that Mr Dyball was adamant he did not want dialysis.[14]

16. Mr Dyball saw Dr Warr on 27 June 2011 and it was noted that Mr Dyball had recently been diagnosed with hepatitis C infection. Mr Dyball ultimately elected not to commence treatment for the infection or to see a liver specialist. He suffered some liver dysfunction in 2015, possibly related to the hepatitis C infection, but he declined to undergo a liver biopsy and no formal diagnosis of liver disease was ever made. A test performed on 7 February 2016 indicated he was still positive for hepatitis C.

17. Mr Dyball declined to attend an appointment with Dr Warr on September 2011 but was reviewed again by Dr Warr on 9 March 2012 and 3 April 2012, when it was noted that his renal function was steadily worsening. It was planned for Mr Dyball to be transferred to Albany Hospital and Dr Warr arranged for a colleague to review him during visits to Albany. He was seen at Albany Hospital on 23 May 2012. Following his hospital review, changes were made to Mr Dyball's blood pressure and cholesterol lowering medications and at least monthly blood tests of renal function were initiated, as well as weekly reviews by a nurse to check for signs of worsening renal failure.

18. In mid-August 2012 Mr Dyball was seen again at Albany Hospital and diagnosed with kidney stones and his renal function had further deteriorated. He was transferred to Royal Perth Hospital on 17 August 2012 for management of a distal ureteric obstruction by a kidney stone and treatment was commenced to prevent further kidney stones forming. His renal function improved somewhat after the kidney stone removal and he had follow-up with urology and nephrology services via Telehealth when he returned to Albany

[11] Exhibit 3, Tab 56 – DIC report and Tab 57.
[12] Exhibit 3, Tab 56 – DIC report.
[13] Exhibit 1, Tab 48A.
[14] Exhibit 1, Tab 48A.

Prison. Telehealth is used quite regularly within the WA public health system, particularly for regional patients.[15]

19. Mr Dyball continued to have his kidney function reviewed by Dr Warr and complications of his kidney disease, such as anaemia, were managed. On 27 November 2012 Dr Warr again discussed the prospect of long-term dialysis with Mr Dyball, but Mr Dyball declined to progress to having a fistula made, and this was confirmed again in January 2013.[16] Mr Dyball moved to Telehealth nephrology consultations after that, at his request.

20. In March 2013 Mr Dyball was admitted to Albany Hospital for investigation of ongoing throat issues. A CT scan found a lesion in the nasopharynx and a lymph node biopsy confirmed squamous cell carcinoma. In consultation with Mr Dyball's renal physician, opiate analgesia was commenced for pain related to the cancer.

21. On 12 April 2013 Mr Dyball was placed on the Terminally Ill Offender Register due to his tonsillar cancer and end stage renal failure.[17] He was moved to Casuarina Prison, where he could be cared for in the Infirmary, on 16 April 2013.[18] He remained in the Casuarina Infirmary for the rest of his imprisonment due to his increasing health needs.

22. In May 2013 Mr Dyball was seen by a Radiation Oncology Registrar and a plan for radiotherapy plus chemotherapy was discussed to treat the cancer, which was on the left tonsil with confirmed spread to lymph nodes in the left side of the neck. Risks were discussed with Mr Dyball and he wished to proceed with treatment, which included teeth extraction.

23. On 14 June 2013 Mr Dyball was admitted to hospital for extraction of teeth prior to starting radiotherapy. During the operation the cancer site started to bleed and a tracheostomy was performed. A PEG tube was inserted as Mr Dyball was unable to eat food. Mr Dyball commenced radiotherapy and chemotherapy treatment in July 2013, which continued until November 2013. Approximately six months after completing radiation treatment Mr Dyball started to eat and drink small amounts and started to show a small improvement in his general symptoms. Mr Dyball then began to refuse to attend scheduled hospital appointments, including follow-up scans to review the progress of the treatments. Telehealth consultations were not suitable for this particular type of review and it was felt Mr Dyball needed to attend the clinic in person. Mr Dyball was eventually reviewed by an Ear, Nose and Throat Consultant at Royal Perth Hospital on 4 December 2014, at which time there was no sign of cancer recurrence. A later scan performed in June 2015 also showed no evidence of recurrence of the cancer.

24. Mr Dyball's final nephrology review occurred via Telephone on 25 February 2016 with a Consultant Nephrologist, Dr George Chin. He was due to be reviewed again in April 2016, although this does not appear to have occurred prior to his sudden deterioration towards the end of April 2016.

[15] T 8.
[16] Exhibit 1, Tab 48A.
[17] Exhibit 3, Tab 56-13.
[18] Exhibit 3, Tab 56 – DIC report.

25. Mr Dyball had also had some investigations that indicated enlarged lymph nodes around his lungs, suggestive of malignancy. A lymph node biopsy was offered, but Mr Dyball declined to proceed. A referral to a respiratory physician was made in the event that Mr Dyball changed his mind, and Mr Dyball was then reviewed at the Respiratory Medicine outpatient clinic at Fiona Stanley Hospital on 27 October 2015. It was not clear whether the enlarged lymph nodes were due to recent infection or malignancy. Options for investigations were felt to be high risk due to Mr Dyball's other medical conditions and in the end it was advised that another scan be performed before a decision about the need for a biopsy was made. A scan performed on 2 December 2015 concluded that the enlarged lymph nodes were less likely to be due to malignancy, so no further investigations were planned.

26. On 28 October 2015 Mr Dyball had been escalated to Stage 4 on the Terminally Ill Prisoner Register.[19] This prompted a review by the Department to determine whether a recommendation should be made for consideration that Mr Dyball be released under the Royal Prerogative of Mercy. Mr Dyball suggested he might be able to live with his brother if released, but an interview with Mr Dyball's brother and assessment of his home concluded the proposed accommodation was unsuitable for Mr Dyball.[20] Ministerial briefings did not recommend release under the Royal Prerogative of Mercy provisions. It was noted in the briefings that Mr Dyball was receiving care equivalent to that provided by the public health system while in prison.[21]

27. Mr Dyball became eligible for release on parole in January 2016 but the Prisoner Review Board denied his release to parole due to inadequate community supports or protective factors, as well as unmet treatment needs.[22] Mr Dyball's family raised some concerns about this decision, but it is outside the scope of my inquest to comment on the decision of the Board on this separate issue.

28. On 8 April 2016 Mr Dyball was seen by Prison Medical Officer Dr Jose Omotoso. Mr Dyball queried why he was still waiting to be seen at Fiona Stanley Hospital for review of his 'lymph node cancer'. He was advised that the doctors at Fiona Stanley did not believe it was cancer and that further investigations were too high risk to perform in those circumstances.

29. On 24 April 2016 Mr Dyball presented to the prison Infirmary and requested diazepam to help him sleep. He reported that he had not slept for the previous three nights. An eConsult was requested and Dr Omotoso prescribed Mr Dyball diazepam 10 mg a night for three nights. The diazepam was duly given during the evening on 24, 25 and 26 April 2016.

30. On 27 April 2016 Mr Dyball was given his weekly Aranesp injection. He did not raise any health concerns at that time. Mr Dyball was self-caring and he spent most of the day resting in his cell. His observations were taken and were within normal limits.

[19] Exhibit 3, Tab 56-13.
[20] Exhibit 3, Tab 56-13 and Tab 56-14.
[21] Exhibit 3, Tab 56 – DIC report.
[22] Exhibit 3, Tab 56 – DIC report.

31. At 4.35 am on Thursday, 28 April 2016 all cells in the Infirmary were checked and all appeared correct.[23]

MR DYBALL'S COLLAPSE

32. At approximately 7.15 am on 28 April 2016 Mr Dyball was found unresponsive in his cell by prison officers conducting the morning unlock. A medical Code Red was initiated and nursing staff arrived almost immediately. They commenced CPR at 7.16 am. An airway could not be inserted and ventilation was provided with a bag valve mask. Attempts at cannulation were not successful. The defibrillator was applied and no shock was advised.[24]

33. St John Ambulance were notified at 7.20 am and the first ambulance arrived at the scene at 7.34 am. Good CPR was noted to be in progress and the heart rhythm on arrival was Pulseless Electrical Activity. Adrenalin was given and there was a return of circulation at 7.51 am. Mr Dyball was given fluids, adrenaline and glucose in transit to Fiona Stanley Hospital. They arrived at the hospital at 8.35 am.[25]

34. On arrival at the hospital Mr Dyball's blood gas showed severe acidosis and he received immediate treatment in the Emergency Department before being transferred to the Intensive Care Unit. Ischaemic changes were seen on the ECG and cardiology doctors were consulted. Medical records indicate the cause of Mr Dyball's cardiorespiratory arrest was not clear. Imaging of Mr Dyball's chest also showed a collapsed right lung and steps were taken to clear the lung and administer antibiotics. Mr Dyball displayed signs of irreversible hypoxic brain injury. The neurology team was consulted and they confirmed that Mr Dyball's clinical presentation and imaging findings were not compatible with any functional recovery.[26]

35. Mr Dyball's sister-in-law had been notified at 8.25 am that Mr Dyball was being taken to Fiona Stanley Hospital due to a medical emergency so that family could attend the hospital.[27] Discussions were held with Mr Dyball's family and a decision was made to withdraw active treatment. He died just after 5.00 pm on 1 May 2016 in the presence of family.[28]

CAUSE AND MANNER OF DEATH

36. A post mortem examination was performed on 3 May 2016 by Dr Jodi White. He was noted to have fluid-laden lungs with florid pneumonia on the right side with adhesions. Mild coronary artery disease was observed and the kidneys were small and scarred with multiple cysts. Scarring was noted at the back of the throat and tongue, consistent with Mr Dyball's history squamous cell

[23] Exhibit 1, Tab 2, p. 2.
[24] Exhibit 1, Tab 14 to 26, 28 - 34.
[25] Exhibit 1, Tab 13.
[26] Exhibit 1, Tab 51.
[27] Exhibit 3, Tab 56-13.
[28] Exhibit 1, Tab 51; Exhibit 3, Tab 56 – DIC report.

cancer involving the left tonsil and tongue. Gross neuropathology confirmed features of hypoxic brain damage.[29]

37. Toxicology analysis showed medications consistent with Mr Dyball's medical care in prison and in hospital, except for the unexpected presence of the drug clozapine, which was not prescribed to Mr Dyball.[30] Clozapine is a drug used in the management of severe schizophrenia and has no other recognised indication. Because of its toxicity, it is only authorised for use in patients who have failed other therapy for schizophrenia and have undergone medical assessments to prove that they are not at particular risk of its toxicity. They then undergo regular medical review while on the therapy. Mr Dyball had no medical reason to have clozapine in his system. It is unclear how he obtained it, although I note that despite intensive efforts by authorities to prevent it, it is well known that the exchange of drugs and medications still occurs regularly between prisoners.[31]

38. At the conclusion of these investigations, Dr White formed the opinion the cause of death was bronchopneumonia complicated by multiorgan failure and hypoxic ischaemic encephalopathy in a man with treated squamous cell carcinoma of the tongue. His chronic renal impairment was also noted. I accept and adopt the opinion of Dr White as to the cause of death.[32]

COMMENTS ON TREATMENT, SUPERVISION AND CARE

39. Mr Dyball had a number of complex medical conditions that required management while he was in prison. As noted above, due to concerns about the standard of health care provided to Mr Dyball, an expert review was sought by this Court from Dr Kong. Dr Kong is a General Physician and Gastroenterologist who practices from the Midland Physician Service at St John of God Midland Public and Private Hospital. Dr Kong was not personally involved in any of Mr Dyball's medical care.[33]

40. Dr Kong reviewed Mr Dyball's medical records and prison records, as well as other material, and provided an opinion on Mr Dyball's medical care for his Chronic Kidney Disease, Left tonsillar/base of tongue squamous cell carcinoma, Chronic Hepatitis C infection and several other health conditions. Dr Kong concluded that the medical care provided to Mr Dyball for all his chronic medical conditions was reasonable and appropriate.[34]

41. In particular, in relation to Mr Dyball's oropharyngeal cancer, Mr Dyball was first noted to have a problem with his tonsil on 30 January 2013. He was reviewed by a Prison Medical Officer almost a month later on 28 February 2013. He was initially given antibiotics before a second review on 6 March 2013, when a lesion was identified. Mr Dyball was referred to hospital and a week later, on 11 March 2013, he was admitted to Albany Hospital and further

[29] Exhibit 1, Tab 5.
[30] Exhibit 1, Tab 6.
[31] Exhibit 1, Tab 50.
[32] Exhibit 1, Tab 5.
[33] Exhibit 1, Tab 48A.
[34] Exhibit 1, Tab 48A.

investigations confirmed on 13 March 2013 that the lesion was a squamous cell carcinoma that had spread to the lymph nodes. A treatment plan was formulated, including PEG tube insertion, teeth extraction, chemotherapy and radiotherapy, which commenced in June and July 2013. Following treatment, Mr Dyball achieved remission from a cancer that was advanced at the time of diagnosis. Dr Kong expressed the opinion that Mr Dyball's care for his cancer was reasonable and appropriate.[35]

42. I note that Mr Dyball frequently refused to attend scheduled medical appointments. It was reported he suffered from travel sickness, so medication for nausea/motion sickness was prescribed to be given prior to travel to and from the hospital, but this did not resolve the issue. It was explained at the inquest that the process of transporting a prisoner to a hospital appointment usually will require security measures such as restraints and strip-searches and the process is time-consuming, so it is not unusual for prisoners with chronic health conditions to choose not to always attend scheduled hospital visits.[36] On some occasions, Mr Dyball also refused to attend specific appointments as it appears he simply felt they were not needed. That was his right as a patient. He was said to be a person who had shown an interest in, and understanding of, his health care, so he was well informed and able to make reasonable decisions about what medical care he chose to accept.[37] Just because he was in prison did not mean he was required to attend appointments against his will and his right to refuse was respected.

43. A review of the hospital medical records also indicates that at times Mr Dyball exhibited challenging behaviours, but treatment continued to be offered and provided appropriately.

44. Dr Kong also reviewed the medical care Mr Dyball received following his cardiac arrest on 28 April 2016. Dr Kong expressed the opinion the medical care was provided to a high standard by attendant prison nursing staff, SJA teams on arrival and later in hospital. Consistent with the observation of the forensic pathologist, Dr Kong observed that it is uncertain what was the triggering factor for Mr Dyball's sudden deterioration. Dr Kong indicated that acute deterioration is often cardiac, vascular or metabolic related and these events are often unpredictable in onset and severity. Mr Dyball's underlying medical co-morbidities also put him at risk of such events.[38]

45. As noted above, toxicology analysis of Mr Dyball's hospital ante-mortem blood sample unexpectedly revealed the presence of the drug clozapine, which was not prescribed to Mr Dyball. Clozapine is a drug used in the management of severe schizophrenia and has no other recognised indication. Because of its toxicity, it is only authorised for use in patients who have failed other therapy for schizophrenia and have undergone medical assessments to prove that they are not at particular risk of its toxicity. They then undergo regular medical review while on the therapy. Mr Dyball had no medical reason to have clozapine in his system. It is unclear how he obtained it, although I note that despite intensive efforts by authorities to prevent it, it is well known that the

[35] Exhibit 1, Tab 48A.
[36] T 8.
[37] Exhibit 3, Tab 57.
[38] Exhibit 1, Tab 48A.

exchange of drugs and medications still occurs regularly between prisoners.[39] Interestingly, clozapine is not a drug that is normally traded as it is not a drug of abuse and would generally have little value to anyone who was not prescribed it. However, it may be that Mr Dyball was mistaken as to the nature of the drug.[40]

46. An expert opinion was obtained from a clinical pharmacologist and toxicologist, Professor David Joyce, in relation to any possible contribution of drugs to Mr Dyball's death, and specifically the clozapine in the post-mortem toxicology results. Overall, Professor Joyce concluded there did not seem to be much reason to suspect that the clozapine had a material role in causing Mr Dyball's death. Further, no other drugs were felt to have played a role in his death.[41] That included the medication Aranesp (Darbopoetin), that Mr Dyball received as a weekly injection for anaemia related to his chronic kidney disease.

47. Shortly before the inquest the Court was advised by the Department that a review of prison documentation raised the remote possibility that Mr Dyball received his Aranesp injection twice in the days prior to his death. The suggestion was raised on the basis that two nursing notes by different nurses on 27 April 2016 referred to an Aranesp injection being given, one note at 1.56 pm and one at 3.03 pm. I note the batch number and expiry date recorded for both injections is the same and the first record refers specifically to the injection being given, whereas the later record is described as a "daily report" and includes reference to the Aranesp injection as part of the daily events.[42]

48. Dr Joy Rowland, the Director of Medical Services for the Department, gave evidence she understood the first record to be a contemporaneous record of the injection being given, and the second record was a duplicate entry of the same event.[43] Dr Rowland also made enquiry with nurses at the Infirmary, who remembered Mr Dyball well and he was a patient who took a close interest in his health and medical care and he was likely to have objected or commented on a second injection being attempted on the same day. This was the only medication he received by injection and he had been receiving a single injection of Aranesp weekly for a considerable length of time. There was also evidence Mr Dyball found the injections painful because the only area where he had sufficient fatty tissue was his abdomen, so he was unlikely to have endured being given a second injection without querying it strenuously.[44] I indicated at the end of the inquest that I was satisfied on the evidence before me that it was a duplication in the documentation and there was no evidence Mr Dyball received a second injection.

[39] Exhibit 1, 6 and Tab 50.
[40] T 18 – 20.
[41] Exhibit 1, Tab 50.
[42] Exhibit 3, Tab 57.
[43] T 12 – 15; Exhibit 3, Tab 57.
[44] T 14 – 15; Exhibit 3, Tab 57, p. 25.

MANNER OF DEATH

49. The exact cause of Mr Dyball's cardiac arrest, which led to his hypoxic brain injury, is not entirely clear. However, it occurred within the context of his long history of serious illness. His chronic renal failure and other health issues increased his risk for acute health events, including collapse and arrest, so he was vulnerable to a cardiac arrest. There was evidence Mr Dyball could have used a cell call to ask for nursing assistance, so it is likely it was a sudden cardiac event that did not allow him an opportunity to call for help.[45]

50. I find that death occurred by way of natural causes.

CONCLUSION

51. Mr Dyball had already been diagnosed with renal disease when he was imprisoned in 2010 and he continued to suffer from chronic renal failure while serving his sentence. During his term of imprisonment he was diagnosed with cancer of the tongue, for which he received treatment and went into remission. He also had a number of health issues, not all of which were investigated due to Mr Dyball's reluctance to undergo what he considered to be unnecessary investigations. That was his right as a patient.

52. Mr Dyball was housed in the Infirmary for most of his sentence, where he could receive regular nursing care and monitoring. He was still in the Infirmary when he was found collapsed in his cell on the morning of 28 April 2016. He was successfully resuscitated and taken to hospital by ambulance, but he had suffered hypoxic brain damage and his condition declined until he died in hospital on 1 May 2016.

53. I am satisfied on the evidence before me that Mr Dyball received a high level of medical care throughout his time in custody until his death.

S H Linton
Coroner
3 June 2020I certify that the preceding paragraph(s) comprise the reasons for decision of the Coroner's Court of Western Australia.

MZ
Judicial Support Officer

9 JUNE 2020

[45] T 17.